SERIES 1

UNICARE STATE INDEMNITY PLAN/BASIC

Benefit Updates and Important Information

Effective July 1, 2009

UniCare®

Commonwealth of Massachusetts
Group Insurance Commission

Updates to the UniCare State Indemnity Plan/Basic Member Handbook

This booklet contains important updates to your UniCare State Indemnity Plan/Basic coverage with and without CIC (Comprehensive Coverage), effective July 1, 2009. Please keep this year's Benefit Update—together with the Series 1 Member Handbook ("Member Handbook")—in a convenient place for easy access when you need to check your health plan information.

This Benefit Update is also available on the Plan's web site: visit **www.unicarestateplan.com** and click on "Forms and Documents" under the "Members" tab. The updates in this booklet will also be incorporated into the next printed version of your Member Handbook.

If you have any questions about these changes, please call UniCare Customer Service at (800) 442-9300, Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. You can also e-mail us from our web site: **www.unicarestateplan.com** (click on "Contact Us"). If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at (800) 322-9161 or (978) 474-5163. A UniCare customer service representative will be happy to help you.

Copays for Medical Services

Beginning July 1, 2009, there is a copay for outpatient high-tech imaging services such as MRIs, CT scans and PET scans at hospital and non-hospital locations. The copay for outpatient high-tech imaging services does not apply when the services are administered as part of emergency room treatment or inpatient hospital care.

In addition, copays for the following services have been changed or added:

- emergency room visits
- physician office visits
- routine eye examinations
- services provided by a nurse practitioner
- outpatient services provided at licensed retail medical clinics

The copay chart in the Your Costs section on page 7 of your Member Handbook is deleted and replaced with the following:

Type of Medical Visit	Without CIC	With CIC
Emergency Room Visit	$75 (waived if admitted)	$75 (waived if admitted)
☎ Outpatient High-Tech Imaging such as MRIs, CT scans and PET scans, at hospital and non-hospital locations	$75 per scan; maximum of one copay per day	$75 per scan; maximum of one copay per day
Physician Office Visits		
Tier 1* (excellent):**		
Primary care physician[1]	$10	$10
Specialty care physician	$15	$15
Tier 2 (good):**		
Primary care physician[1]	$25	$25
Specialty care physician	$25	$25
Tier 3* (standard):		
Primary care physician[1]	$30	$30
Specialty care physician	$35	$35
Services Provided by Nurse Practitioners	$25	$25
Physical Therapy and Occupational Therapy	$15	$15
Chiropractic Care	$15	$15
Routine Eye Examinations		
With an optometrist	$25	$25
With an ophthalmologist	See specialty care physician office visit copays above	See specialty care physician office visit copays above
Licensed Retail Medical Clinics at Pharmacies	$15	$15

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300.

1 Primary care physicians are pediatricians, and physicians specializing in family medicine, general medicine and/or internal medicine. Some primary care physicians may also be specialty care physicians and, if so, may be considered to be specialists in the determination of their tier and copay assignments. This means you will pay the office visit copay for the type of practice the physician has been designated to, regardless of whether you see the physician for a primary care or specialty care visit.

Physician Tiering

The information on the Group Insurance Commission's Clinical Performance Improvement (CPI) Initiative in the Your Costs section on page 10 of your Member Handbook is deleted and replaced with the following:

To help you make more informed choices about your health care options and to control your premium costs, the Group Insurance Commission's (GIC) Clinical Performance Improvement (CPI) Initiative includes a physician tiering program. Under this program, Massachusetts physicians are assigned to tiers based on an evaluation of various quality and cost-efficiency measures for physicians. Based on a comparison of their scores with their peers in the same specialties on these efficiency measures, as well as whether the physician met certain quality benchmarks, individual physicians are assigned to one of three tiers, as described below. The names of the tiers have been assigned by the GIC for use uniformly across all of its participating health plans.

- **Tier 1***** (Excellent) – Tier 1 physicians are those who met or exceeded the quality assessment threshold, established for all physicians, and ranked at the highest level of cost-efficiency, as compared to their peers. Tier 1 is designed to acknowledge the high performance of these physicians in terms of both quality and cost-efficiency measures, as determined by the available data.
- **Tier 2**** (Good) – Tier 2 physicians are those who demonstrate good practice patterns. They have met or exceeded the quality assessment threshold established for all physicians and have met the cost-efficiency threshold established by the Plan, but did not achieve scores as high as Tier 1 physicians.
- **Tier 3*** (Standard) – Tier 3 physicians are those who did not meet the quality threshold established for all physicians, or they did not meet the cost-efficiency threshold established by the Plan.

Note: For a variety of reasons, many physicians did not have sufficient data available during the data collection period to allow us to assess their quality and/or cost-efficiency. Some may lack sufficient data with regard to the quality measures and/or the cost-efficiency measures. These physicians are placed in the category of Not Tiered/Insufficient Data (NT/ID). You can see these physicians for a Tier 2-level copay.

You will find detailed explanations about the assignment of doctors to tiers and about the methods used to determine the quality and cost-efficiency scores of the physicians at www.unicarestateplan.com under "Forms and Documents." You can also call the Andover Service Center at (800) 442-9300 to request materials.

The methodology used in this tiering process relies on nationally accepted approaches to evaluating both quality and efficiency, and uses claims data submitted by health care providers themselves. The use of claims data has some limitations, and there are additional methods that you may wish to use in evaluating the quality and efficiency of providers. In making decisions about choosing your providers, you should consider the potential limitations in the data as well as other factors that correlate with the quality of care that you receive, some of which may be subjective in nature, but which are important to you.

How to Find out Your Physician's Tier Designation

To find out which tier your physician is in, log onto the Plan's web site: www.unicarestateplan.com; under "Find a Provider" click on the link for the "Physician Tier Listing." You can also check the printed Provider Listing, or call the Andover Service Center at (800) 442-9300 for assistance.

High-Tech Imaging Services at Hospital and Non-Hospital Locations

There is now a $75 copay per scan (maximum of one copay per day) for outpatient high-tech imaging services at hospital and non-hospital locations. The copay for outpatient high-tech imaging does not apply when services are administered as part of emergency treatment and/or inpatient care.

The following changes are made to your Member Handbook to reflect this change:

A. The copay chart in the Your Costs section on page 7 of your Member Handbook is deleted and replaced with the copay chart on page 3 in this Benefit Update.

B. The coverage for "Non-Emergency Treatment" in the Benefit Highlights section on page 27 of your Member Handbook is deleted and replaced with the following:

	Without CIC	With CIC
Emergency Room Charge	100% after the emergency room copay; waived if admitted	100% after the emergency room copay; waived if admitted
Radiology other than high-tech imaging	80%	100%
☎ High-tech imaging such as MRIs, CT scans and PET scans as part of an emergency room treatment and/or as part of inpatient care	80%	100%
☎ High-tech imaging such as MRIs, CT scans and PET scans	80% after the applicable copay, per scan; maximum of one copay per day	100% after the applicable copay, per scan; maximum of one copay per day
Diagnostic Laboratory	100%	100%

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300.

For deductible and copay amounts, see the charts in the Your Costs section. All services must be medically necessary and all charges will be subject to Reasonable and Customary Allowed Amount.

C. The coverage for "Outpatient Medical Care" in the Benefit Highlights section on page 28 of your Member Handbook is deleted and replaced with the following:

	Without CIC	With CIC
For Services at a Hospital (other than the services listed below)	100%	100%
Diagnostic Laboratory Testing	100%	100%
Radiology other than high-tech imaging	80%	100%
☎ High-tech imaging such as MRIs, CT scans and PET scans	80% after the applicable copay, per scan; maximum of one copay per day	100% after the applicable copay, per scan; maximum of one copay per day
Licensed Retail Medical Clinics at Pharmacies	80% after the applicable copay	100% after the applicable copay
☎ Physical Therapy ☎ Occupational Therapy	100% after the applicable copay	100% after the applicable copay
Speech Therapy	80% up to a maximum benefit of $2,000 per calendar year	100%, up to a maximum benefit of $2,000 per calendar year
Chemotherapy	80%	100%

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section of your Member Handbook for specific notification requirements and responsibilities. For copay amounts, see the chart on page 3 of this benefit update. For deductible amounts, see the chart on page 6 of your Member Handbook. All services must be medically necessary and all charges will be subject to Reasonable and Customary Allowed Amount.

D. The definition, "Advanced Radiology Procedures" on page 50 of your Member Handbook is deleted and replaced with the following:

"High-Tech Imaging Services" – Applies to tests that are sometimes referred to as "advanced radiology procedures." These tests vary from plain film x-rays by offering providers a more comprehensive view of the human body. Many of these tests also subject members to significantly higher levels of radiation compared to plain film x-rays and are also much more expensive. These procedures include but are not limited to MRIs, CT scans and PET scans.

Coverage for Nurse Practitioners

The Plan now covers services provided by nurse practitioners for primary care, intermediate care and inpatient care.

The following changes are made to your Member Handbook to reflect this change:

A. An item has been added to page 39 of the Description of Covered Services section as follows:

Nurse Practitioners – Medically necessary services provided in a hospital, clinic, professional office, home care setting, long-term care setting or any other setting when services are provided by a nurse practitioner who is practicing within the scope of his/her license.

B. Item 3 in the Limitations section on page 48 of your Member Handbook is deleted and replaced with the following:

3. **Assistant surgeon services** are limited to the services of only one assistant surgeon per procedure when medically necessary. Second and third assistants are not covered.

   Non-physician assistants at surgery, such as physician assistants (PAs), nurse practitioners, nurses and technicians are not covered. Interns, residents and fellows are also not covered. Chiropractors, dentists, optometrists and certified midwives are not covered as surgical assistants or as assistant surgeons.

C. The definition of **"Physician"** in the Plan Definitions section of your Member Handbook on page 54 is deleted and replaced with the following:

"Physician" – the term "physician" includes the following health care providers acting within the scope of their licenses or certifications:

1. physician
2. certified nurse midwife
3. chiropractor
4. dentist
5. nurse practitioner
6. optometrist
7. podiatrist

Coverage for Services Provided at Licensed Retail Medical Clinics

You can now receive coverage for limited health care services at licensed retail medical clinics, which are located at certain pharmacies. These clinics offer care provided by nurse practitioners or physician assistants for basic primary medical services. Examples of such services include treatment for an earache or sinus infection.

The following changes are made to your Member Handbook to reflect this change:

A. The chart in the Benefit Highlights section on page 28 of your Member Handbook is updated in the "Outpatient Medical Care" chart on page 6 of this Benefit Update.

B. An item has been added to page 40 of the Description of Covered Services section as follows:

Retail Medical Clinics – charges for medically necessary services for episodic, urgent care such as treatment for an earache or sinus infection at licensed retail medical clinics located at certain pharmacies. Flu vaccines may also be administered at these clinics.

C. An item has been added to page 49 in the Limitations section as follows:

Retail Medical Clinics are limited to providing care within the scope of their license in the state in which they are providing services.

D. The following definition is added to the list in the Plan Definitions section on page 55 of your Member Handbook:

"Retail Medical Clinics" – Licensed medical clinics located at certain pharmacies that provide services by nurse practitioners or physician assistants for basic primary medical services. These services are limited to episodic, urgent care such as treatment for an earache or sinus infection. Retail medical clinics are limited to providing care within the scope of their license in the state in which they are providing services.

Nonpayment for Serious Preventable Adverse Health Care Events

An item has been added to page 47 of your Member Handbook as follows:

Costs associated with serious preventable adverse health care events are not covered, in accordance with Department of Public Health (DPH) regulations. Massachusetts providers are not permitted to bill members for designated serious reportable health care events. For more information on this policy and a list of these events, visit **www.unicarestateplan.com** and click on "Forms and Documents" under the "Members" tab.

Outpatient Surgery Quarterly Deductible

Please note that the outpatient surgery deductible does not apply to freestanding surgical facilities or outpatient surgery performed in a physician's office. The subsection, **"Outpatient Surgery Quarterly Deductible"** on page 7 of your Member Handbook is deleted and replaced with the following:

Outpatient Surgery Quarterly Deductible

The outpatient surgery quarterly deductible is a per-person, per-calendar year quarter deductible. Each time you or a covered dependent has outpatient surgery at a hospital, you are responsible for paying this deductible. However, once a covered person satisfies the outpatient surgery quarterly deductible in any calendar year quarter, he or she will not have to satisfy this deductible again during that same calendar year quarter. This deductible does not apply when you have outpatient surgery at a freestanding ambulatory surgical facility or at a physician's office.

Designated Hospital Definition

The following definition has been added to page 51 of the Plan Definitions section of your Member Handbook:

"Designated Hospital" – a hospital designated by the Plan for which the benefits are covered at a higher level for transplant services.

Exclusions

The following items have been added to the Exclusions section on pages 45–47 of your Member Handbook as follows:

- Any physical therapy services provided by athletic trainers
- Services received at non-medical religious facilities

Continued Coverage for Dependents Age 19 and over

The subsection, "Continued Dependent Coverage" on page 57 of your Member Handbook has been changed and replaced with the following:

Continued dependent coverage: A dependent child who reaches age 19 is no longer automatically eligible for coverage under this Plan. In order to continue coverage for a dependent age 19 and over, you must complete all of the following steps:

1. Complete the written application that the GIC will send you prior to the dependent's 19th birthday;
2. Complete subsequent eligibility recertification forms; and
3. Return all of the completed forms as instructed by the GIC. If the forms are returned late, your dependent may have a gap in coverage.

The following types of dependents age 19 and over are eligible for coverage:

- Student Dependents: Coverage is available under a family plan for a child who is a full-time student at the age of 19 and enrolled in an accredited educational institution. Members must apply to the GIC for student dependent coverage. The GIC requires verification of full-time student status for any member enrolled as a student dependent under a family plan.
- Full-time Students Age 26 and over: A full-time student at an accredited educational institution at age 26 or over may elect to continue coverage as an individual member under the Plan at 100% of the required premium. That student must file a written application with the GIC and the application must be approved by the GIC.
- A dependent age 19 or over but under age 26 who is a dependent under the Internal Revenue Code is eligible for coverage under this Plan.
- A dependent age 19 or over until the earlier of two years following the loss of dependent status under the Internal Revenue Code or age 26 is eligible for coverage under this Plan.

Note: Failure to recertify coverage when required will result in termination of continued dependent coverage.

For more information, see the subsection, "When Coverage Ends for Dependents" on page 58 of your Member Handbook.

Group Health Continuation Coverage under COBRA

The following replicates the information on pages 60–63 of your Member Handbook. However, we re-print it in this Benefit Update as important information about your health Plan. Also, see the section "COBRA Subsidy and Special Extended Election Notice" on page 13 of this update. This notice contains new, 2009–2010 information on your COBRA benefits.

This subsection contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

What is COBRA coverage?

COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a Federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This information explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage contact the GIC's Public Information Unit at (617) 727-2310, ext. 1, or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's web site at **www.dol.gov/ebsa.**

Who is eligible for COBRA coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced, or
- Your employment ends for reasons other than gross misconduct

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies
- Your spouse's employment with the Commonwealth, municipality or other entity ends for any reason other than gross misconduct or his/her hours of employment are reduced, or
- You and your spouse divorce or legally separate

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced
- The parents divorce or legally separate, or
- The dependent ceases to be a dependent child

How long does COBRA coverage last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event—the insured's death or divorce—occurs during the 18 months of COBRA coverage.

You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security**

Administration's disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid in full when due (see section on paying for COBRA)
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability)
- Your employer no longer provides group health coverage to any of its employees, or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud)

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and when do I elect COBRA coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under Federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How much does COBRA coverage cost?

Under COBRA, you must pay 102 percent of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150 percent of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and when do I pay for COBRA coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.**

After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I elect other health coverage besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance "conversion" policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA Coverage Responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced
  - The employee or former employee dies
  - The employee divorces or legally separates
  - The employee or employee's former spouse remarries
  - A covered child ceases to be a dependent
  - The Social Security Administration determines that the employee or a covered family member is disabled, or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

COBRA Subsidy and Special Extended Election Notice

The following information has been added to the end of the subsection, "Group Health Continuation Coverage under COBRA" in your Member Handbook.

This notice contains important information about additional rights to continue your GIC health coverage and, for some people, at a temporarily reduced premium. **Please read the information contained in this notice very carefully.**

If you have lost coverage due to an involuntary termination some time between September 1, 2008 and December 31, 2009 and you are not eligible for Medicare or other group health plan coverage, you may be eligible for a temporary premium reduction in COBRA rates for up to nine months. Furthermore, if you lost coverage due to an involuntary termination some time between September 1, 2008 and February 17, 2009 AND either did not elect COBRA continuation coverage at that time or you elected COBRA but discontinued the coverage, you may be eligible for a second election opportunity.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces COBRA premium in some cases. Read this notice attached to help determine if you are eligible for COBRA at a temporarily reduced premium of 35% of the usual COBRA rate for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. If you believe you meet the criteria for the COBRA premium reduction, contact the GIC for COBRA premium reduction rates and an application, and return it to the GIC with your completed COBRA election form. You do not have to send payment with your application. If you elect COBRA and are eligible for the premium reduction, COBRA continuation coverage will begin on the date you lost your GIC-sponsored coverage, or retroactively on March 1, 2009 if you avail yourself of the Special Extended Election opportunity. The retroactive coverage is required by Federal law.

You must complete the GIC COBRA subsidy application forms and return to the GIC by no later than 60 days after you receive this notice by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114, or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage. If you have any questions about this notice or your rights to COBRA continuation coverage, contact the GIC's Public Information Unit at (617) 727-2310, ext. 1, or visit the GIC at 19 Staniford Street, 4th Floor, Boston, MA 02114.

Important Information about Your COBRA Continuation Coverage Rights

Am I eligible for COBRA at reduced rates?

If you lost group health coverage from September 1, 2008 through December 31, 2009 due to an involuntary termination of employment that occurred during that period and are not eligible for Medicare or other group health plan coverage, you are entitled to receive the premium reduction. Information about the amount of the premium reduction and how it affects your premium payments can be found below.

How long will the premium reduction last?

The premium reduction will last for up to nine months as long as you:

- Are eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- Have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- Are not eligible for Medicare; AND
- Are not eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.

Am I eligible to elect COBRA continuation coverage at this time through the Special Extended Election?

Only individuals who lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period, and who did not elect COBRA continuation coverage during their first election period OR who elected but subsequently discontinued COBRA coverage (for reasons other than becoming eligible for another group health plan or Medicare), are entitled to elect coverage at this time. If you lost group health coverage for any other reason between these dates and did not elect COBRA continuation coverage when it was first offered, you are not entitled to this second election period.

How long will continuation coverage last?

Your coverage generally will begin on the first of the month after the month in which you were involuntarily terminated and can generally continue for up to 18 months from the date of your involuntary termination of employment. The duration of the premium reduction is determined separately and may not last for the entire length of your COBRA coverage.

Continuation coverage will be terminated before the end of the 18-month period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

When and how must the first payment for COBRA continuation coverage be made?

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Public Information Unit, Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-8747 (617) 727-2310, ext 1 to confirm the correct amount of your first payment.

For More Information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Group Insurance Commission. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of the health plan handbook, you may contact the Public Information Unit, Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-8747 (617) 727-2310, ext 1.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Group Insurance Commission.

Plan Notification Requirements

You or your provider must notify the Andover Service Center of certain treatments, services or procedures within the required time frames. See the subsection, "Managed Care Notification Requirements" on pages 17–20 of your Member Handbook.

Minimum Maternity Confinement Benefits

The subsection, "Minimum Maternity Confinement Benefits" on page 22 of your Member Handbook remains unchanged. Therefore, the following information replicates the information in your Member Handbook. However, we are legally required to re-send this information to our members every year.

Minimum Maternity Confinement Benefits

Coverage is provided for inpatient hospital services for a mother and newborn child for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery, and
2. 96 hours following an uncomplicated caesarean section

Any decision to shorten the minimum confinement period will be made by the attending physician in consultation with the mother. If a shortened confinement is elected, coverage will include one home visit for post-delivery care.

Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The health care services provided must include, at a minimum:

1. parent education
2. assistance and training in breast or bottle feeding, and
3. performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed health care provider.

You must notify the Plan as soon as you know your or your dependent(s)' expected due date or at least seven (7) days in advance of your admission. You must notify the Plan again within one (1) business day of being admitted to the hospital. Please call a patient advocate at the Andover Service Center if you have questions.

Coverage for Reconstructive Breast Surgery

The subsection, "Reconstructive Breast Surgery" on page 35 of your Member Handbook remains unchanged. Therefore, the following information replicates the information in your Member Handbook. However, Federal law requires us to re-issue this information to our members every year.

3. Reconstructive breast surgery:

   (a) all stages of breast reconstruction following a mastectomy

   (b) reconstruction of the other breast to produce a symmetrical appearance after mastectomy

   (c) prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate deductibles and coinsurance amounts.

Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is applicable and is more generous than the Federal law, your benefits will be paid in accordance with your state's law.

Coordination of Benefits (COB)

The subsection, "Coordination of Benefits (COB)" on page 13 of your Member Handbook remains unchanged. However, we provide this annual reminder that if you have medical benefits under another health plan in addition to the UniCare State Indemnity Plan, you need to let us know by completing our "Other Health Insurance" form. This way, we can work with the other health plan to determine which plan has primary responsibility for providing coverage for each service.

This provision lets members with coverage under another plan use the coverage available to them under **all** health plans in which they are enrolled.

You must also complete the "Other Health Insurance" form if any of your **family members** covered under the UniCare State Indemnity Plan also have medical benefits under another health plan.

Important: **You do not have to complete the "Other Health Insurance" form if you only have health plan coverage under the UniCare State Indemnity Plan. It is not necessary to tell us about coverage under:**

- MassHealth
- Tricare, or
- other types of coverage such as dental, vision or life insurance plans

How to Get a Copy of the "Other Health Insurance" Form

- ***New*** **Plan Members:** You'll find a copy of this form in your welcome package.
- ***Renewing*** **Plan Members:** You can download this form from our web site: **www.unicarestateplan.com** by clicking on the link for "Other Health Insurance Form" on the Forms and Documents web page. Or call UniCare Customer Service at (800) 442-9300 to request the form.

Need Help?

If you're not sure whether you need to complete the Other Health Insurance Form, a customer service representative can help you. Please call UniCare Customer Service at (800) 442-9300.

Prescription Drug Plan

Administered by:

EXPRESS SCRIPTS®

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan.

The following information replaces the section, "Prescription Drug Plan" on pages 65–74 of your Member Handbook.

Description of Benefits

The following benefit changes are effective July 1, 2009:

- Copayments for all medications, including specialty medications, have changed.
- The Value Tier has been discontinued.
- Non-sedating antihistamines (e.g., Allegra-D, Clarinex) will no longer be covered; over-the-counter (OTC) alternatives are available.

If you have any questions about your prescription drug benefits, contact the Express Scripts Customer Service Call Center toll free at (877) 828-9744, TDD: (800) 855-2881.

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter version of Prilosec (Prilosec OTC), medications are covered only if a prescription is required for their dispensing. Diabetic supplies and insulin are also covered by the plan.

The plan categorizes medications into six major categories:

Generic Drugs

Generic versions of brand medications contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs.

Maintenance Drug

A maintenance drug is a medication taken on a regular basis for conditions such as asthma, heartburn, high-blood pressure or high-cholesterol.

Non-Preferred Brand Name Drug

A non-preferred brand name drug, or non-formulary drug, is a medication that usually has an alternative therapeutically-equivalent drug available.

Preferred Brand Name Drug

A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost-effectiveness.

Specialty Drugs

Specialty drugs are injectable and noninjectable drugs that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements
- Cost in excess of $500 for a 30-day supply

Over-the-Counter (OTC) Drugs

Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Prilosec OTC (which is covered if dispensed with a written prescription).

Copayments

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit. The following chart shows your copayment based on the type of prescription you fill and where you get it filled.

Copayment for	Participating Retail Pharmacy up to 30-day supply	Home Delivery up to 90-day supply
Tier 1 **Generic Drugs and** ▪ Prilosec OTC *(28-day supply – retail; 84-day supply – mail)**	$10	$20
Tier 2 **Preferred Brand Name Drugs**	$25	$50
Tier 3 **Non-Preferred Brand Drugs and** ▪ COX-2 inhibitors *(pain and inflammation – Celebrex)*	$50	$110
Copayment for	**Specialty Drugs – Must Be Filled Only Through CuraScript**	
Specialty Drugs: Tier 1	$10 up to a 30-day supply	
Specialty Drugs: Tier 2	$25 up to a 30-day supply	
Specialty Drugs: Tier 3	$50 up to a 30-day supply	

*Due to manufacturer packaging

How to Use the Plan

Filling Your Prescriptions

You may fill your prescriptions at a participating retail pharmacy or through Express Scripts Home Delivery (Mail Order). Prescriptions for specialty drugs must be filled through CuraScript.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your Express Scripts ID card, with the exception of the limited circumstances detailed in the "Claim Forms" subsection.

Short-Term Medication Needs – Up to 30 Days

Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (example: antibiotics for strep throat or painkillers for an injury). Simply present your Express Scripts ID card to your pharmacist, along with your written prescription, and pay the required copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online at www.express-scripts.com or by calling toll free at (877) 828-9744.

If you do not have your ID card, you can provide your pharmacist with the cardholder's Social Security or GIC ID number, and the group number, which is GICA. The pharmacist will also be able to verify eligibility by contacting the Express Scripts Pharmacy Help Desk toll free at (800) 824-0898, TDD: (800) 842-5754.

If you are filling maintenance medications at a retail pharmacy, you may receive phone calls and/or letters from Express Scripts explaining how to convert your maintenance medications to mail order. You will need to let Express Scripts know if you would like to use mail order or instead to continue using a retail pharmacy. Express Scripts will either assist you in transitioning your maintenance medications to mail order, or if you choose not to use mail, they will continue to make sure you receive your maintenance medications at retail.

Long-Term Medication Needs

Filling Your Prescriptions Through the Express Scripts Pharmacy

Home Delivery (Mail Order) is your best option for prescription drugs (other than specialty drugs filled through CuraScript) that you take on a regular basis for conditions such as asthma, heartburn, high-blood pressure, and high-cholesterol. Your prescriptions are filled and double-checked by Express Scripts' licensed pharmacists and conveniently sent to you in a plain, weather-resistant pouch for privacy and protection.

Convenient for You

You get up to a 90-day supply of your medications—which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using Home Delivery, you can order refills online, by phone or by mail.

Using Home Delivery

To begin using Home Delivery for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a Home Delivery order form. (You can obtain a Home Delivery order form and envelope anytime online at www.express-scripts.com or by calling toll free at (877) 828-9744.)
3. Put your prescription, payment and completed order form into the mail order envelope and mail it to Express Scripts.

Your prescription drug will be mailed to your home in 10 to 14 business days from the day you mailed the prescription to Express Scripts, with no charge for standard U.S. Postal Service delivery. You can request overnight delivery for an additional charge.

A pharmacist is available 24 hours a day to answer your questions about your medication.

If the Express Scripts pharmacy is unable to fill a prescription because of a shortage of the medication, Express Scripts will notify you of the delay in filling the prescription. You may then attempt to fill the prescription at a retail pharmacy, but the retail pharmacy copayment will then apply.

Express Scripts' Specialty Pharmacy

CuraScript is a full-service specialty pharmacy that provides personalized care to each patient. All specialty drugs must be filled through CuraScript pharmacy. You are allowed two fills of your specialty drug(s) at a participating retail pharmacy. After these two fills, your specialty drug(s) will no longer be covered through other pharmacies.

CuraScript offers a complete range of services and specialty drugs—many of which are often unavailable at retail pharmacies. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You can save time with convenient toll-free access to expert clinical support staff who are available to answer all of your specialty drug questions. CuraScript will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CuraScript, call CuraScript toll free at (866) 848-9870.

CuraScript Services

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office or other approved location
- **Refill Reminders** – Ongoing refill reminders from CuraScript
- **Language Assistance** – Language interpreting services are provided for non-English speaking patients

CuraScript serves a wide range of patient populations, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, post-transplant needs and more.

Claim Forms

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your Express Scripts ID card, are covered as follows:

Type of Claim	Reimbursement
Claims for prescriptions for enrollees who reside in a nursing home or live or travel outside the U.S. or Puerto Rico.*	Claims will be reimbursed at the full cost submitted less the applicable copayment.
Claims for purchases at a participating (in-network) pharmacy without an Express Scripts ID card.	Claims incurred within 30 days of the enrollee's eligibility effective date will be covered at full cost, less the applicable copayment. -or- Claims incurred more than 30 days after the enrollee's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.

*Claims for medications filled outside the United States and Puerto Rico are covered only if the medications have U.S. equivalents.

Visit express-scripts.com

Get the Information You Need When You Need It

Express-scripts.com provides 24-hour online access to information regarding your prescription benefit. Visit the website to:

- Find out about your copayment amounts
- Verify coverage for eligible dependents
- View or print a list of drugs included in your formulary
- Locate participating retail pharmacies near you
- Review your 12-month prescription history
- Order refills online
- Check the status of your mail order prescription

Register Now to Access express-scripts.com

Accessing your prescription benefit online is quick, easy and secure; just go to www.express-scripts.com and complete a brief registration process to get started. You'll have the information you need about your prescription benefits, right at your fingertips.

Other Plan Provisions

Generics Preferred

Generics Preferred is a program that encourages the use of generic drugs. There are some brand name drugs, such as Ambien and Fosamax, for which generic equivalents are available. If you fill a prescription for a brand-name medication for which there is a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment.

Prescription Drugs with OTC Equivalents or Alternatives

Some prescription drugs have OTC equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products. Your plan does not provide benefits for these prescription drugs.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are very similar to the prescription drugs. For example, OTC alternatives to Clarinex, a prescription drug, are the OTC products Claritin and Zyrtec. Your plan does not provide benefits for prescription drugs when OTC alternatives are available.

Prior Authorization

Some drugs on your plan require prior authorization. If a drug that you take requires prior authorization, your physician will need to contact Express Scripts to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call (800) 417-8164.

Drugs that currently require Prior Authorization*

- Actiq
- Amevive
- Aralast
- Aranesp
- Amevive
- Avonex
- Betaseron
- Botox
- Byetta
- Cerezyme
- Copaxone
- Enbrel
- Epogen
- Euflexxa
- Fabrazyme
- Fentora
- Forteo
- Growth Promoting Agents
- Humira
- Hyalgan
- Immune Globulin Products
- Kineret
- Lamisil
- Myobloc
- Neulasta
- Neupogen
- Orencia
- Orthovisc
- Pegasys
- Peg-Intron
- Penlac
- Privigen
- Procrit
- Prolastin
- Raptiva
- Rebif
- Regranex
- Remicade
- Revatio
- Somavert
- Sporanox
- Supartz
- Synvisc
- Tazorac
- Topamax
- Tysabri
- Vfend
- Weight Loss Drugs such as Xenical and Merida
- Xolair
- Zemaira
- Zonegran

For members over the age of 35: Retin-A, Retin-A Micro, Avita, Tretin-X, Atralin gel, topical tretinoin, Ziana

*This list may change during the plan year.

Quantity Per Dispensing Limits

To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits are based on the following:

- The manufacturer's recommended dosage and duration of therapy
- Common usage for episodic or intermittent treatment
- FDA-approved recommendations and/or clinical studies
- As otherwise determined by your plan

Examples of drugs with quantity limits currently include Actonel, Avandia, Flonase, Imitrex, Lunesta, Levitra, and Viagra.*

Step Therapy

In some cases, your plan requires the use of less expensive first-line prescription drugs before the plan will pay for more expensive second-line prescription drugs. First-line prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases. Your prior claims history, if you are a continuing member of the plan, will show whether first-line prescription drugs have been purchased within the previous 160 days, allowing the more-expensive medication to be approved without delay.

If you have not had a medication filled within the previous 160 days while a member of this plan, it is not considered a current prescription and the Step Therapy requirements will apply to your prescription.

In certain situations, a member may be granted an authorization for a second-line prescription drug without the prior use of a first-line prescription drug if specific medical criteria have been met.

Unless you meet certain medical criteria or have a prior history of use of the first-line prescription drug, your pharmacist will receive a message that the prescription will not be covered. The message will list alternative, first-line drugs that could be used. You or your pharmacist will then need to contact your physician to have your prescription changed, or you will have to pay the full cost of the prescription. If you are using Home Delivery, Express Scripts will notify you of a delay in filling your prescription and will contact your physician about switching to a first-line prescription drug. If your physician does not respond within two business days, Express Scripts will not fill your prescription and will return it to you.

*This list may change during the plan year.

Current examples of second-line prescription drugs requiring Step Therapy*	
ADD/ADHD	Strattera
Allergies	Accolate, Nasacort AQ, Rhinocort Aqua, Singulair, and Zyflo
Antidepressants	Celexa, Cymbalta, Effexor XR, Lexapro, Paxil CR and Zoloft
Antipsychotic	Symbyax
Diabetes	Actos, Avandia, Avandamet, Avandaryl, Duetact
High-Blood Pressure	Accupril, Aceon, Altace, Atacand/HCT, Avapro, Avalide, Cardene, Coreg, Cozaar/HCT, Diovan/HCT, Lexxel, Lotrel, Mavik, Micardis/HCT, Monopril/HCT, Norvasc, Sular, Tarka, Teveten, Toprol XL and Uniretic
High-Cholesterol	Caduet, Lescol, Lipitor and Zetia
Incontinence	Detrol LA, Enablex, Oxytrol, Sanctura, VESIcare
Insomnia	Ambien CR, Lunesta, Rozerem and Sonata
Neuropathy	Lyrica
Pain/Arthritis	Arthrotec, Celebrex, Ponstel and Mobic
Stomach Ulcers	Aciphex, Nexium, Prevacid and Protonix
Topical Dermatitis	Elidel and Protopic

*This list may change during the plan year.

Drug Utilization Review Program

Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the plan;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Too early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be processed.

Exclusions

Benefits exclude:*

- Smoking cessation programs or medications
- Dental preparations
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and Prilosec OTC)
- Vitamins or minerals prescribed in the absence of certain medical conditions (with the exception of prenatal vitamins)
- Homeopathic drugs
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of 18
- Allergens
- Hair growth agents
- Special medical formulas or food products, except as required by state law

Definitions

Brand Name Drug – The brand name is the trade name under which the product is advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 17 years. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

Diabetic Supplies – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

Formulary – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts formulary contains a wide range of generic and preferred brand name products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in either the retail pharmacy or home delivery settings. The formulary is developed and maintained by Express Scripts. Formulary designations may change as new clinical information becomes available.

Generic Drugs – Generic versions of brand medications contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The U.S. Food and Drug Administration (FDA) requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs.

Maintenance Drug – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, heartburn, high-blood pressure or high-cholesterol.

Non-Preferred Brand Name Drug – A non-preferred brand name drug, or non-formulary drug, is a medication that has been reviewed by the Express Scripts Pharmacy and Therapeutics Committee, which determined that an alternative drug that is clinically equivalent and more cost-effective may be available.

Over-the-Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Prilosec OTC (which is covered if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the Express Scripts nationwide network. All major pharmacy chains and most independently-owned pharmacies participate.

Preferred Brand Name Drug – A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost-effectiveness.

Prescription Drug – A prescription drug is any medical substance, the label of which under the Federal Food, Drug, and Cosmetic Act, must bear the legend: "Caution Federal Law prohibits dispensing without a prescription." The term prescription drug also includes insulin and diabetic supplies.

Prior Authorization – Prior authorization means determination of medical necessity. It is required before prescriptions for certain drugs will be paid by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

For inherited diseases of amino acids and organic acids, food products modified to be low protein are covered up to $5,000 per calendar year per member. To access the benefit for special medical formulas or food products, members must first call the Group Insurance Commission at (617) 727-2310, extension 1.

Specialty Drugs – Specialty drugs are injectable and noninjectable drugs that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements
- Cost in excess of $500 for a 30-day supply

Other Plan Information

Claims Inquiry

If you believe your claim was incorrectly denied or you have questions about a prescription, call Express Scripts Customer Service Call Center toll free at (877) 828-9744, TDD: (800) 855-2881.

Health and Prescription Information

Health and prescription information about members is used by Express Scripts to administer your benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of your benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

United Behavioral Health
Mental Health, Substance Abuse and Enrollee Assistance Programs
Effective July 1, 2009

The following information is provided as a clarification to the information found in your Member Handbook. Effective July 1, 2009 there will be changes to your Mental Health, Substance Abuse and EAP Programs for United Behavioral Health/Optum Health Behavioral Solutions.

The Benefits Chart on pages 84–85 of your Member Handbook has been changed and is replaced with the following:

Covered Services	Network	Out of Network
Annual *Deductible*	None	$150 per person (a, b) $300 per family (a, b) Medicare Extension (OME): $100 per person (a, b) RMT/EGR: $75 per person (a, b)
Out-of-Pocket Maximum	$1,000 per individual (a) $2,000 per family	$3,000 per member (a) No family maximum
Benefit Maximums	Unlimited	Unlimited
Inpatient Care		
Deductible	$200 per calendar quarter (a, c) Basic: $150 per calendar quarter (a, c) Medicare Extension (OME): $50 per calendar quarter (a, c)	$150 per admission (applies after annual *deductible* is met) (a)
Mental Health General Hospital Psychiatric Hospital Substance Abuse General Hospital or Substance Abuse Facility	 Full coverage Full coverage	80% of *allowed charges* (d)
Intermediate Care (Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Examples are residential treatment, group homes, halfway houses, day/ partial hospitals, or structured outpatient programs.)	Full coverage	80% of *allowed charges* after *deductible* is met (d)
	All inpatient and intermediate care must be precertified. Emergency admissions must be precertified within 24 hours to receive maximum benefits. Non-notification penalty for failure to precertify care is $200. Non-notification penalty does not count toward out-of-pocket maximums.	

Outpatient Care (e, f) – Mental Health, Substance Abuse and Enrollee Assistance Program (EAP)		
Enrollee Assistance Program (EAP)	Up to 3 visits: 100%	No Coverage for EAP
	EAP *non-notification penalty* reduces benefit to zero: no benefits paid.	
Individual and Family Therapy	100%, after $15 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Group Therapy	100%, after $10 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, g)
Medication Management: (15–30 minute psychiatrist visit)	100%, after $10 per visit	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, f)
In-Home Mental Health Care	Full coverage	First 15 visits: 80% of *allowed charges* (e, f) Visits 16 and over: 50% of *allowed charges* (e, f)
Drug Testing (as an adjunct to substance abuse treatment)	Full coverage	No coverage
	Non-notification penalty reduces benefit to zero: no benefits paid.	
Provider Eligibility – Provider must be licensed in one of these disciplines.	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g)	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g)

(a) Separate from medical *deductible* and medical *out-of-pocket maximum*. *Network* and *out-of-network out-of-pocket maximums* do not *cross accumulate*.

(b) *Cross accumulates* with all *Out-of-network* mental health and substance abuse benefit levels.

(c) Waived if readmitted within 30 days: maximum one *deductible* per calendar quarter.

(d) Out-of-network care that is not preauthorized is subject to financial penalty and retrospective review.

(e) All care requires preauthorization.

(f) All *Out-of-network* visits in a given calendar year are accumulated to determine the appropriate *out-of-network* level of reimbursement.

(g) Massachusetts independently licensed providers: psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied mental health professionals.

Please note: The words in italics have special meanings that are given in the Glossary section.

Part III – Benefits Explained

Please replace the sections titled "Out-of-Network Services" and "Out-of-Network Benefits" within section "Part III – Benefits Explained" on pages 87–88 in your Member Handbook in its entirety with the following, new "Out-of-Network Services" and "Out-of-Network Benefits" sections.

Out-of-Network Services

Care from an *out-of-network provider* is paid at a lower level than network care. *Out-of-network* care is subject to *deductibles* and *coinsurance*.

Benefits are paid based on *allowed charges* that are UBH/Optum Health Behavioral Solutions reasonable and customary fees or negotiated fee maximums. If your *out-of-network provider* or facility charges more than these *allowed charges*, you may be responsible for the difference, in addition to any amount not covered by the benefit.

Out-of-network mental health and substance abuse treatment is subject to a $150 per person/$300 per family calendar year *deductible*.[1] Calendar year *deductibles* must be met prior to inpatient *deductibles* and *cross accumulate* between all out-of-network mental health and substance abuse benefit levels.

The *out-of-pocket maximum* for out-of-network care is $3,000 per person.

The following do not count toward the *out-of-pocket maximum*:

- Out-of-network calendar year *deductibles*
- Out-of-network inpatient *deductibles*
- *Non-notification penalties*
- Cost of treatment found to not be a *covered service*
- Charges in excess of UBH's *allowed charges*

***Authorization* will be required for all out-of-network outpatient care. The member will automatically be allowed 10 sessions. However, the provider needs to have care reviewed after 10 sessions in order for the member to obtain authorization for additional sessions.**

Out-of-Network Benefits

Outpatient Care – Outpatient visits deemed to be a covered service are paid at 80% of UBH's *allowed charges*, up to the 15th visit after your $150 annual deductible is met. Visits 16 and over are paid at 50% of UBH/Optum Health Behavioral Solution's *allowed charges*. Out-of-network, outpatient visits need to be *precertified*. The first 10 visits will be automatically allowed, but visits 11 and over are subject to provider care review.

In-Home Care – Included in outpatient care. Visits deemed to be a covered service are paid at 80% of UBH/Optum Health Behavioral Solution's allowed charges, up to the 15th visit after your $150 annual deductible is met. Visits 16 and over are paid at 50% of UBH's *allowed charges*.

Intermediate Care – *Intermediate care* deemed to be a *covered service* is paid at 80% after appropriate annual *deductibles* have been met. All facility (intermediate and inpatient) care must be *precertified*. Emergency admissions must be *precertified* within 24 hours to receive maximum benefits. Non-notification penalty for failure to *precertify* is $200 and your coverage may be reduced for failure to *precertify*. Non-notification penalty does not count towards out-of-pocket maximums.

1 The $300 per family calendar year deductible does not apply to the UniCare State Indemnity Plan/Medicare Extension (OME).

Inpatient Care – *Out-of-network* inpatient care deemed to be a *covered service* for mental health care is paid at 80% in a general hospital and at 80% in a psychiatric hospital. Inpatient care for substance abuse treatment deemed to be a *covered service* is paid at 80% in a general hospital or substance abuse facility.

Each admission to a hospital or facility is subject to a $150 inpatient *deductible* per person in addition to the calendar year *deductible*. Failure to *precertify* inpatient care is subject to a *non-notification penalty* of $200 if the UBH/Optum Health Behavioral Solutions case manager determines that the care is a *covered service*. No benefits will be paid if it was found not to be a *covered service*.

Drug Testing – There is no coverage for out-of-network drug testing.

There is no coverage for *out-of-network* EAP services.

See pages 88–90 of your Member Handbook for a list of Exclusions.

Appeals

You may initiate your appeal in writing or verbally by contacting UBH/Optum Health Behavioral Solutions at the address or toll-free number listed below.

United Behavioral Health/
Optum Health Behavioral Solutions
Appeals Department
100 East Penn Square
Suite 400
Philadelphia, PA 19107
Toll-Free Telephone: (800) 548-6549 ext. 39291
Fax Number: (888) 881-7453

Appendix A: GIC Notices

This information replicates the section, "Your Prescription Drug Coverage and Medicare" on pages 95–96 of your Member Handbook. However, we repeat it in this Benefit Update as an important reminder about your health plan.

Your Prescription Drug Coverage and Medicare

Important Notice about Your Prescription Drug Coverage and Medicare

The Centers for Medicare Services requires that this NOTICE OF CREDITABLE COVERAGE be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. This notice:

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE MEDICARE DRUG PLANS, SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

Medicare Drug Plans

The Medicare prescription drug benefit, also known as Medicare Part D, is offered through various health plans and other organizations. All Medicare prescription drug plans provide at least the standard level of coverage set by Medicare; some plans also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan or Tufts Health Plan Medicare Preferred (formerly Secure Horizons), you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at (800) 772-1213 (TTY: (800) 325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage pays. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. If your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1 percent per month for every month after May 15, 2006 (or the month of your 65th birthday, whichever is later) that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call (800) MEDICARE – (800) 633-4227. TTY users should call (877) 486-2048.
- Visit www.medicare.gov.
- Call the Group Insurance Commission at (617) 727-2310.

Appendix B: Disclosure When Plan Meets Minimum Standards

*This health plan **meets the Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see additional information below.*

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets the Minimum Creditable Coverage standards** that became effective July 1, 2008 as part of the Massachusetts Health Care Reform Law. If you are covered under this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR THE MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER YOUR HEALTH PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Notes

UniCare State Indemnity Plan
Andover Service Center
P.O. Box 9016
Andover, MA 01810-0916
(800) 442-9300
www.unicarestateplan.com

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